STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX
Petitioner **File No. 86833-001**

v

Blue Cross and Blue Shield of Michigan
Respondent
_____/

Issued and entered
This 23rd day of January 2008
by Ken Ross
Acting Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On December 20, 2007, XXXXX on behalf of XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The Commissioner reviewed the request and accepted it for external review on January 2, 2008.

The Commissioner notified Blue Cross and Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Office of Financial and Insurance Services received BCBSM's response on January 11, 2007.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM Flexible Blue Group Benefits Certificate (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

On August 7, 2007, the Petitioner underwent heart bypass surgery. These services were provided by XXXXX. who is a non-participating provider. BCBSM paid $3,869.86 of the $8,400.00 charged by the surgeon. This left the Petitioner to pay the balance of $4,530.14.

The Petitioner appealed BCBSM's payment amount. BCBSM held a managerial-level conference on November 13, 2007, and issued a final adverse determination November 29, 2007.

III
ISSUE

Is BCBSM required to pay an additional amount for the surgery provided the Petitioner on August 7, 2007?

IV
ANALYSIS

Petitioner's Argument

The Petitioner says he had an angiogram on August 6, 2007. The results were so poor he was immediately admitted to the hospital and scheduled for quadruple heart bypass surgery the next morning. The surgery was successful.

The Petitioner was disappointed to learn that he is being asked to pay for charges in excess of the reasonable and customary fees of the provider. He faced an emergency situation that required immediate intervention. He did not have the luxury of finding out how much BCBSM would pay for his care.

The Petitioner argues that there was only one qualified surgeon in the area that could perform his surgery. The Petitioner believes that all the charges should be covered by BCBSM.

BCBSM's Argument

Section 4 of the certificate, *Coverage for Physician and Other Professional Services,* explains how BCBSM pays nonpanel and nonparticipating providers (as a nonparticipating provider,

(XXXXX is also a nonpanel provider). It says that BCBSM pays its "approved amount" for physician and other professional services -- the certificate does not guarantee that charges will be paid in full.

The amounts charged by the surgeon and the amounts paid by BCBSM for the August 7, 2007 surgery are set forth in this table:

Procedure Code	Amount Charged	BCBSM's Approved Amount	Petitioner's Balance
12 33533	$5,000.00	$2,621.39	$2,378.61
12 33519	$2,000.00	$686.19	$1,313.81
18 33533	$1,000.00	$445.63	$554.37
18 33533	$400.00	$116.65	$283.35
Total	$8,400.00	$3,869.86	$4,530.14

BCBSM says it paid the same amount it would have paid to a participating surgeon, no deductibles or copayments were applied. However, since the surgeon did not participate with BCBSM, he is not required to accept BCBSM's approved amount as payment in full.

In determining the maximum payment level for each service, BCBSM says it applies the Resource Based Relative Value Scale (RBRVS), a nationally recognized reimbursement structure developed by and for physicians. The RBRVS reflects the resources required to perform each service. BCBSM regularly reviews the ranking of procedures to address the effects of changing technology, training, and medical practice.

BCBSM believes that it has paid the proper amount for the Petitioner's care by a nonpanel provider and is not required to pay any additional amount.

Commissioner's Review

The certificate describes how benefits are paid. It explains that BCBSM pays an "approved amount" for physician and other professional services. The approved amount is defined in the certificate as the "lower of the billed charge or [BCBSM's] maximum payment level for a covered service." Participating and panel providers agree to accept the approved amount as payment in full

for their services. Nonparticipating providers have no agreement with BCBSM to accept the approved amount as payment in full and may bill for the balance of the charges.

The certificate says (on pages 4.23 – 4.24):

> If the nonpanel provider is **nonparticipating**, you will need to pay most of the charges yourself. Your bill could be substantial. . . .
>
> **NOTE**: Because nonparticipating providers often charge more than our maximum payment level, our payment to you may be less than the amount charged by the provider.

BCBSM paid its approved amount for the Petitioner's surgery, no deductible or copayment was applied.

It is unfortunate that the Petitioner was in a situation where he was not able to use a participating surgeon. Nevertheless, there is nothing in the terms and conditions of the Petitioner's certificate that requires BCBSM to pay more than its approved amount to a nonparticipating provider even if the services were provided on an emergency basis or no participating provider was available.

The Commissioner finds that BCBSM has paid the Petitioner's claims correctly according to the terms of the certificate and is not required to pay more for the Petitioner's care.

V
ORDER

BCBSM's final adverse determination of November 29, 2007 is upheld. BCBSM is not required to pay an additional amount for the Petitioner's care provided by XXXXX.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.